

## SECTION 1915(c) WAIVER FORMAT

1. The State of Alaska requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a.          Yes

b. X No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a. 3 years (initial waiver)

b. X 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. X      Nursing facility (NF)

b. \_\_\_\_\_ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

c. \_\_\_\_\_ Hospital

d. \_\_\_\_\_ NF (served in hospital)

e. \_\_\_\_\_ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. aged (age 65 and older)

b. X disabled

c. \_\_\_\_\_ aged and disabled

- d. \_\_\_\_\_ mentally retarded
- e. \_\_\_\_\_ developmentally disabled
- f. \_\_\_\_\_ mentally retarded and developmentally disabled
- g. \_\_\_\_\_ chronically mentally ill
4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):
- a. \_\_\_\_\_ Waiver services are limited to the following age groups (specify):
- b. \_\_\_\_\_ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. \_\_\_\_\_ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. X Other criteria. (Specify):  
Adults 21-64 with physical disabilities who would receive long term care in a facility for more than 30 days per year. If the APD waiver client turns age 65 while on the waiver, the client may continue to be eligible for the APD waiver services as long as the client meets all eligibility requirements.
- e. \_\_\_\_\_ Not applicable.
5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.
- a. Yes                      b. X No

7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a. ☐ Yes    b. ☐ No    c. ☒ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ☐ Yes    b. ☒ No

9. A waiver of the "state-wideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. ☐ Yes    b. ☒ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

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10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

- a. ☒ Case management  
b. ☐ Homemaker  
c. ☐ Home health aide services  
d. ☐ Personal care services  
e. ☒ Respite care  
f. ☒ Adult day health  
g. ☒ Habilitation

- ☒ Residential habilitation
- ☒ Day habilitation
- ☐ Prevocational services
- ☒ Supported employment services
- ☒ Educational services
- h. ☒ Environmental accessibility adaptations
- i. ☐ Skilled nursing
- j. ☒ Transportation
- k. ☒ Specialized medical equipment and supplies
- l. ☒ Chore services
- m. ☐ Personal Emergency Response Systems
- n. ☐ Companion services
- o. ☐ Private duty nursing
- p. ☐ Family training
- q. ☐ Attendant care
- r. ☐ Adult Residential Care
- ☐ Adult foster care
- ☐ Assisted living
- s. ☐ Extended State plan services (Check all that apply):
- ☐ Physician services
- ☐ Home health care services
- ☐ Physical therapy services
- ☐ Occupational therapy services

\_\_\_\_\_ Speech, hearing and language services

\_\_\_\_\_ Prescribed drugs

\_\_\_\_\_ Other (specify):  
\_\_\_\_\_

t.   X   Other services (specify):

- 1) Meals Services.
- 2) Residential Supported Living Arrangements.
- 3) Intensive Active Treatment/Therapies.
- 4) Specialized Private Duty Nursing

u. \_\_\_\_\_ The following services will be provided to individuals with chronic mental illness:

\_\_\_\_\_ Day treatment/Partial hospitalization

\_\_\_\_\_ Psychosocial rehabilitation

\_\_\_\_\_ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a.   X   When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
  - b.   X   Meals furnished as part of a program of adult day health services.
  - c.            When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
    - 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
    - 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
    - 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
  - b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
  - 1. Informed of any feasible alternatives under the waiver; and
  - 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a.   X   Yes                      b.        No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.
- a. \_\_\_\_ Yes                      b. X No
18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.
19. An effective date of July 1, 2001 is requested.
20. The State contact person for this request is Jon Sherwood, MAA IV, who can be reached by telephone at (907) 465-3355.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: \_\_\_\_\_  
Print Name: Karen Perdue  
Title: Commissioner, Department of Health and Social Services  
Date: July 24, 2001



## APPENDIX A - ADMINISTRATION

## LINE OF AUTHORITY FOR WAIVER OPERATION

## CHECK ONE:

\_\_\_\_\_ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

  X   The waiver will be operated by the Division of Senior Services, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

The waiver program will formally interact with the following programs funded under other State or Federal authorities (specify):

## Department of Health and Social Services

- Division of Family and Youth Services
- Division of Public Assistance
- Division of Public Health
- Division of Medical Assistance
- Division of Mental Health and Developmental Disabilities

## Department of Administration

- Adult Protective Services
- Assisted Living Licensing
- Office of Public Advocacy

## Department of Revenue

- Long Term Care Ombudsman

\_\_\_\_\_ The waiver will be operated by \_\_\_\_\_, a separate division of the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

## APPENDIX B - SERVICES AND STANDARDS

## APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

## a. \_\_\_\_\_ Case Management

\_\_\_\_\_ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. In Alaska, Case Management is referred to as Care Coordination.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. \_\_\_\_\_ Yes                      2. \_\_\_\_\_ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. \_\_\_\_\_ Yes                      2. \_\_\_\_\_ No

  X   Other Service Definition (Specify): In Alaska, Case Management is referred to as Care Coordination.

Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services.

Care Coordinators shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

Care Coordinators shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

Within the context of HCB waiver services care coordination includes the following functions:

Evaluation and/or reevaluation of the need for waiver services, development and/or review of the plan of care, coordination of multiple services and/or providers, monitoring of quality of care, review of medical necessity of waiver services.

Monitoring service provision, ensuring the scope, amount, frequency and duration will be established and as appropriate to the client's Plan of Care.

Client contact of not less than twice every a month, one of which must be face to face, to ensure service provision, client health and safety, and client satisfaction with Plan of Care services.

b. \_\_\_\_\_ Homemaker:

\_\_\_\_\_ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

\_\_\_\_\_ Other Service Definition (Specify):

c. \_\_\_\_\_ Home Health Aide services:

\_\_\_\_\_ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

\_\_\_\_\_ Other Service Definition (Specify): \_\_\_\_\_

## d. \_\_\_\_\_ Personal care services:

\_\_\_\_\_ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

## 1. Services provided by family members (Check one):

\_\_\_\_\_ Payment will not be made for personal care services furnished by a member of the individual's family.

\_\_\_\_\_ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

## Justification attached. (Check one):

\_\_\_\_\_ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

\_\_\_\_\_ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

## 2. Supervision of personal care providers will be furnished by (Check all that apply):

\_\_\_\_\_ A registered nurse, licensed to practice nursing in the State.

\_\_\_\_\_ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

\_\_\_\_\_ Case managers

\_\_\_\_\_ Other (Specify):

## 3. Frequency or intensity of supervision (Check one):

☐ As indicated in the plan of care

☐ Other (Specify):  
\_\_\_\_\_

## 4. Relationship to State plan services (Check one):

☐ Personal care services are not provided under the approved State plan.

☐ Personal care services are included in the State plan, but with limitations. The Waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

☐ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

☐ Other service definition (Specify):

e. ☒ Respite care:

☒ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

☐ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

☒ Individual's home or place of residence

☒ Foster home (Licensed Assisted Living Home)

☒ Medicaid certified Hospital

☒ Medicaid certified NF

☐ Medicaid certified ICF/MR

X   Group home (Licensed Assisted Living Home)

  X   Licensed respite care facility (Licensed Assisted Living Home)

       Other community care residential facility approved by the State that is not a private residence (Specify type):

       Other service definition (Specify):

f.   X   Adult day health: (Alaska regulations refer to this service as “Adult Day Care”)

       Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.        Yes

2.        No

  X   Other service definition (Specify):

Adult Day Care: services designed to provide a variety of health, social and related support services in a protective setting during any part of a day, but less than 24-hour care. Individuals who participate in adult day care attend on a planned basis during specified hours. Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals a day). Physical, occupational and speech activities prescribed as part of therapies indicated in the recipient’s plan of care may be furnished as component parts of this service. Meals, physical, occupational and speech therapies may be provided and billed separately.

Transportation between the recipient’s place of residence and the adult day care center may be provided as a component part of the adult day care services. If it is provided, it will be billed separately, and will not be included in the rate paid for adult day care services.

g.   X   Habilitation:

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

X Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision that would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation, which shows that Medicaid payment does not cover these components, is attached to Appendix G.

X Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

\_\_\_\_ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.  
Check one:

\_\_\_\_\_ Individuals will not be compensated for prevocational services.

\_\_\_\_\_ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

  X   Educational services, which consist of special education and services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

  X   Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:



1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
1. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.   x   Yes

2.        No

       Other service definition (Specify):

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The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h.   X   Environmental accessibility adaptations: (Alaska regulations refer to this service as "Environmental Modifications")

       Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

  X   Other service definition (Specify):

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Each environmental modification must have a specific adaptive purpose that provides accessibility and safety.

i. \_\_\_\_\_ Skilled nursing:

\_\_\_\_\_ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

\_\_\_\_\_ Other service definition (Specify):  
\_\_\_\_\_

j. X \_\_\_\_\_ Transportation:

X \_\_\_\_\_ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

k. X \_\_\_\_\_ Specialized Medical Equipment and Supplies:

- X   Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

l.   X   Chore services:

- X   Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

m. \_\_\_\_\_ Personal Emergency Response Systems (PERS)

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

n. \_\_\_\_\_ Adult companion services:

\_\_\_\_\_ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

o. \_\_\_\_\_ Private duty nursing:

\_\_\_\_\_ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

p. \_\_\_\_\_ Family training:

\_\_\_\_\_ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

q. \_\_\_\_\_ Attendant care services:

\_\_\_\_\_ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

\_\_\_\_\_ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

\_\_\_\_\_ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided In State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

\_\_\_\_\_ Other supervisory arrangements (Specify): \_\_\_\_\_

\_\_\_\_\_ Other service definition (Specify):

r. \_\_\_\_\_ Adult Residential Care (Check all that apply):

\_\_\_\_\_ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed \_\_\_\_). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

\_\_\_\_\_ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and

which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- ☐ Home health care
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Medication administration
- ☐ Intermittent skilled nursing services
- ☐ Transportation specified in the plan of care
- ☐ Periodic nursing evaluations
- ☐ Other (Specify):

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

☐ Other service definition (Specify): \_\_\_\_\_

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or

indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. \_\_\_\_\_ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

\_\_\_\_\_ Physician services

\_\_\_\_\_ Home health care services

\_\_\_\_\_ Physical therapy services

\_\_\_\_\_ Occupational therapy services

\_\_\_\_\_ Speech, hearing and language services

\_\_\_\_\_ Prescribed drugs

\_\_\_\_\_ Other State plan services (Specify): \_\_\_\_\_

t.   X   Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

1. Meal Services: Hot or other appropriate meals which each meet at least one-third of the daily Recommended Dietary Allowance, served to recipients in their homes or day program sites that are necessary to prevent institutionalization. Meals shall not constitute a "full nutritional regimen".

2) Residential Supported Living Arrangements: Services in a variety of settings in which assistance with activities of daily living and other services are provided, necessary to prevent institutionalization. Payments for residential supported living arrangements are not made for room and board, the cost of administering a facility or group home, or the costs of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the requirements of the applicable life safety code. Payments will not be made, directly or indirectly, to members of the recipient's immediate family, nor will it be made for the routine care and supervision which would be expected to be provided by a family or group home provider or for activities or supervision for which a payment is made by a source other than Medicaid.

3) Specialized Private Duty Nursing: Services consist of individual and continuous care or part time or intermittent care provided by licensed nurses within the scope of the State's Nurse Practice Act. The intermittent, part time care may offer assessment, monitoring and patient education. The nurse will develop a nursing plan of care which supports the client's waiver plan of care. These services are provided to an individual at home. Specialized Private Duty Nursing Services are tailored to the specific needs of a particular client and are necessary to prevent institutionalization.

4) Intensive Active Treatment/Therapies: The provision of treatment or therapy provided by a professional which is oriented to a client-specific problem. These time-limited interventions are designed to address a family problem, or a personal, social, behavioral, mental or substance abuse disorder in order to maintain or improve effective functioning. Intensive active treatment services are determined necessary when intervention requires precision and knowledge possessed only by specific disciplines, and specially trained professionals. Services may be utilized when an individual needs intervention to decelerate regression of behaviors; requires rapid skill development and acquisition or the service is necessary to prevent institutionalization.

u. \_\_\_\_\_ Services for individuals with chronic mental illness, consisting of (Check one):

\_\_\_\_\_ Day treatment or other partial hospitalization services (Check one):

\_\_\_\_\_ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),



- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

\_\_\_\_\_ Psychosocial rehabilitation services (Check one):

\_\_\_\_\_ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

\_\_\_\_\_ Other service definition (Specify): \_\_\_\_\_

\_\_\_\_\_ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

- ☐ This service is furnished only on the premises of a clinic.
- ☐ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

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**APPENDIX B-2****PROVIDER QUALIFICATIONS****A. LICENSURE AND CERTIFICATION CHART**

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Qualified individuals may become certified as a Care Coordination and/or HCB Agency.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	Other Standard
Case Management/ Care Coordination	DSS HCB Agency  DSS Care Coordination Agency		Certified by DSS under 7AAC 43.1090	
In-home hourly respite	HCB Agency		Certified by DSS under 7AAC 43.1090	
Out-of-home Daily respite	HCB Agency  Hospital Or Nursing Home	Licensed Hospital or nursing facility	Certified by DSS under 7AAC 43.1090	
Residential Habilitation	DMHDD HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Day Habilitation	DMHDD HCB Agency		Certified by DMHDD under 7 AAC 43.1090	
Adult Day Care	DSS HCB Agency		Certified by DSS under 7AAC 43.1090	
Supported Employment Services	DSS HCB Agency		Certified by DSS under 7AAC 43.1090	
Educational Services	DSS HCB Agency		University of Alaska, under AS 14.40.010	
Environmental Modifications	DSS HCB Agency or Licensed Contractor	Contractors licensed under 12 AAC 21.010-21.990	Certified by DSS under 7AAC 43.1090	

SERVICE	PROVIDER	LICENSE	CERTIFICATION	Other Standard
Transportation	HCB Agency  DMA transportation provider	Alaska State Driver's License	Certified by DSS under 7AAC 43.1090 Division of Medical Assistance	
Specialized Medical Equipment and supplies	Medical Supply vendor	Alaska business license		
Residential Supported Living Arrangements	DSS HCB Agency	HCB Agency  Assisted living home license	Certified by DSS under 7 AAC 43.1090  Certified by DSS under 7AAC 75	
Chore	DSS HCB Agency		Certified by DSS under 7AAC 43.1090	
Meals	ACoA Grantee funded to provide meals or, Certified school lunch programs		DEC Certification 18 AAC31  Department of Education 42 CFR 440.180 (b)	
Specialized Private Duty Nursing	HCB Agency		Certified by DSS under 7 AAC 43.1090	Licensed Medicare Home Health Agency or Hospice agency.
Intensive Active Treatment Therapies	DSS HCB Agency		Certified by DSS under 7AAC 43.1090	

## B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

## C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

## D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

## APPENDIX B-3

## KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

## KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

## APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- \_\_\_\_\_ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- \_\_\_\_\_ X A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

**SECTION 1915(c) WAIVER FORMAT****APPENDIX C-Eligibility and Post-Eligibility****Appendix C-1--Eligibility****MEDICAID ELIGIBILITY GROUPS SERVED**

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.   x   Low income families with children as described in section 1931 of the Social Security Act.
2.   x   SSI recipients (SSI Criteria States and 1634 States).
3.        Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4.   x   Optional State supplement recipients
5.        Optional categorically needy aged and disabled who have income at (Check one):
  - a.        100% of the Federal poverty level (FPL)
  - b.        % Percent of FPL which is lower than 100%.
6.   x   The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

  x   A. Yes                             B. No

Check one:

- a.   x   The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b.\_\_\_\_ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)\_\_\_\_ A special income level equal to:

\_\_\_\_ 300% of the SSI Federal benefit (FBR)

\_\_\_\_% of FBR, which is lower than 300% (42 CFR 435.236)

\$\_\_\_\_ which is lower than 300%

(2)\_\_\_\_ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)\_\_\_\_ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4)\_\_\_\_ Medically needy without spenddown in 209(b) States.  
(42 CFR 435.330)

(5)\_\_\_\_ Aged and disabled who have income at:

a.\_\_\_\_ 100% of the FPL

b.\_\_\_\_% which is lower than 100%.

(6)\_\_\_\_ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.\_\_\_\_ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. x Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

See attachments to Appendix C: Categories of Medicaid Eligibility



## **Appendix C-2--Post-Eligibility**

### **GENERAL INSTRUCTIONS**

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

### **REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735**

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

### **SPOUSAL POST-ELIGIBILITY--1924**

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY**REGULAR POST ELIGIBILITY**

1. x **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. ' 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. x The following standard included under the State plan (check one):

(1)\_\_\_ SSI

(2)\_\_\_ Medically needy

(3) x The special income level for the institutionalized

(4)\_\_\_ The following percent of the Federal poverty level): \_\_\_%

(5)\_\_\_ Other (specify): \_\_\_\_\_

B. \_\_\_ The following dollar amount: \$ \_\_\_\_\_ \*

\* If this amount changes, this item will be revised.

C. \_\_\_ The following formula is used to determine the needs allowance:

**Note:** If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. \_\_\_ SSI standard

B. \_\_\_ Optional State supplement standard

C. \_\_\_ Medically needy income standard

D. \_\_\_ The following dollar amount:

\$ \_\_\_\_\_ \*

\* If this amount changes, this item will be revised.

E. \_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_% of \_\_\_\_ standard.

F. \_\_\_\_ The amount is determined using the following formula:

G. x Not applicable (N/A)

3. Family (check one):

A. \_\_\_\_ AFDC need standard

B. \_\_\_\_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. \_\_\_\_ The following dollar amount:  
\$ \_\_\_\_\_ \*

\*If this amount changes, this item will be revised.

D. \_\_\_\_ The following percentage of the following standard that is not greater than the standards above: % \_\_\_\_ of \_\_\_\_ standard.

E. \_\_\_\_ The amount is determined using the following formula:

F. \_\_\_\_ Other

G. x Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY**REGULAR POST ELIGIBILITY**

1.(b)\_\_\_ **209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. \_\_\_ The following standard included under the State plan (check one):

(1) \_\_\_ SSI

(2) \_\_\_ Medically needy

(3) \_\_\_ The special income  
level for the institutionalized

(4) \_\_\_ The following percentage of  
the Federal poverty level: \_\_\_%

(5) \_\_\_ Other (specify):

B. \_\_\_ The following dollar amount: \$ \_\_\_ \*

\* If this amount changes, this item will be revised.

C. \_\_\_ The following formula is used to determine the amount:

**Note:** If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. \_\_\_ The following standard under 42 CFR 435.121:

B.\_\_\_\_ The medically needy income standard \_\_\_\_\_;

C.\_\_\_\_ The following dollar amount: \$\_\_\_\_\_\*

\* If this amount changes, this item will be revised.

D.\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_% of

E.\_\_\_\_ The following formula is used to determine the amount:

F.\_\_\_\_ Not applicable (N/A)

3. family (check one):

A.\_\_\_\_ AFDC need standard

B.\_\_\_\_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.\_\_\_\_ The following dollar amount: \$\_\_\_\_\_\*

\* If this amount changes, this item will be revised.

D.\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_% of \_\_\_\_\_standard.

E.\_\_\_\_ The following formula is used to determine the amount:

F.\_\_\_\_ Other

G.\_\_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

## POST ELIGIBILITY

## SPOUSAL POST ELIGIBILITY

2.   x   The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:  
(check one)

(a)          SSI Standard

(b)\_\_\_ Medically Needy Standard

(c)   x   The special income level for the institutionalized

(d)\_\_\_ The following percent of the Federal poverty level:  
\_\_\_\_%

(e)\_\_\_\_\_ The following dollar amount \$\_\_\_\_\_\*\*

**\*\*If this amount changes, this item will be revised.**

(f) The following formula is used to determine the needs allowance:

(g)\_\_\_ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

<b>Adults with Physical Disabilities</b>		
<b>Category</b>	<b>Social Security Laws</b>	<b>Federal Regs</b>
Post-Partum	1902(e)(5) and (6)	
Pregnant Women	1902(e)(6) 1902(a)(10)(A)(i)(III) 1902(l)(1)(A)	42 CFR 435.116 42 CFR 435.170
Transitional Medicaid	1902(a)(10)(ii)(XIV)	42 CFR 435.112
4-month Post Medicaid	1902(a)(10)(A)(i)(I) 1931	42 CFR 435.115(f)
"1619" Eligible / Ineligible for SSI/APA	1619(b)(1) 1619(b)(3)	42 CFR 435.120
"Pickle People" Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977	Sec. 503 of P.L. 94-566 1928(a)(5)(E)	42 CFR 435.135
Individuals eligible for Medicaid in 1973	None	42 CFR 435.131 42 CFR 435.132 42 CFR 435.133
Individuals eligible for AFDC or SSI if not in a medical institution	1902(a)(10)(ii)(IV)	42 CFR 435.211
Retroactive Medicaid	1902(a)(34) 1905(a)	
Breast & Cervical Cancer	1902(a)	
Working Disabled Medicaid Buy-In	1902(a)(10)(A)(ii)(XIII) 1905(s)	None
Disabled Children at Home (TEFRA)	1902(e)(3) 1915(c)(10)	42 CFR Part 435 Subpart G and F
Disabled Widow(er)s	1634(b)	42 CFR 435.137 42 CFR 435.138
SSI "Disabled Adult Children"	1634(c)	42 CFR 435.122
Ineligible for SSI or APA because of Requirements prohibited by Medicaid	None	42 CFR 435.122
QDWI	1902(a)(10)(E)(ii) 1905(s)	



APPENDIX D  
ENTRANCE PROCEDURES AND REQUIREMENTS

## APPENDIX D-1

## a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

## b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

\_\_\_\_\_ Discharge planning team

\_\_\_\_\_ Physician (M.D. or D.O.)

  X   Registered Nurse, licensed in the State

  X   Licensed Social Worker

\_\_\_\_\_ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

\_\_\_\_\_ Other (Specify):

## APPENDIX D-2

## a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

\_\_\_\_\_ Every 3 months

\_\_\_\_\_ Every 6 months

  X   Every 12 months

\_\_\_\_\_ Other (Specify):  
\_\_\_\_\_

## b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

  X   The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

\_\_\_\_\_ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

\_\_\_\_\_ Physician (M.D. or D.O.)

\_\_\_\_\_ Registered Nurse, licensed in the State

\_\_\_\_\_ Licensed Social Worker

\_\_\_\_\_ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

\_\_\_\_\_ Other (Specify):  
\_\_\_\_\_

## c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care  
(Check all that apply):

  X   "Tickler" file

  X   Edits in computer system

  X   Component part of case management

       Other (Specify) \_\_\_\_\_

## APPENDIX D-3

## a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

☐ By the Medicaid agency in its central office

☐ By the Medicaid agency in district/local offices

☒ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

☒ By the case managers

☒ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

☐ By service providers

☐ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

## b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

☒ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

☐ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

## ALASKA LONG TERM CARE ASSESSMENT

### **Instructions**

The Alaska Long Term Care Assessment (ALTCA) must be completed by a Medicaid Waiver Care Coordination provider. The assessment is required for all persons seeking Medicaid home and community-based waiver services from the Division of Senior Services.

**SECTION I** (pages 1-4): Comprehensive Assessment for HCB Waiver Level of Care Eligibility

**SECTION II** (pages 5-13): Comprehensive Assessment for HCB Waiver Plan of Care

Both sections must be completed for all new applicants seeking placement on a HCB Waiver Program for persons eligible for the level of care provided in a nursing facility:

- Children with Complex Medical Conditions
- Older Alaskans 65+ years of age
- Adults with Physical Disabilities 21-64 years of age

Level of Care is authorized for 365 days. Level of Care should be renewed prior to the anniversary date. Submit the following documents for clients due for annual Waiver Level of Care Reauthorization:

- Section I: pages 1-4 with new medical certification and care coordinator signatures
- Section II: Submit all pages.

The documents required for each long-term care program are indicated below. Refer to the Medicaid Waiver Desktop Manual for additional information.

LONG TERM CARE PROGRAM	SECTIONS REQUIRED TO BE COMPLETED
<b>HCB Waiver Program for Children with Complex Medical Conditions</b>	Medicaid Long Term Care Referral Screening Guide, Proof of DPA Application, ALTCA (pages 1-13)  Upon LOC approval from DSS, Care Coordinators will be authorized by DMHDD to complete Plan of Care.
<b>HCB Waiver Program for Older Alaskans</b>	Medicaid Long Term Care Referral Screening Guide, Proof of DPA Application, ALTCA (pages 1-13).  Upon LOC approval from DSS, submit plan of care and cost sheet.
<b>HCB Waiver Program for Adults with Physical Disabilities</b>	Medicaid Long Term Care Referral Screening Guide, Proof of DPA Application, ALTCA (pages 1-13).  Upon LOC approval from DSS, submit plan of care and cost sheet.

**SECTION I (pages 1-4): Comprehensive Assessment for HCB Waiver Level of Care Eligibility**

Date of Screen: _____		<b>PERMANENT CLIENT INFORMATION</b>	
Name: _____		Mail _____	
Address: _____		(last) (first) (middle initial)	
City: _____		State: _____ Zip: _____ Phone: _____	
Date of Birth: _____ Age: _____ Social Security #: _____ Medicaid # _____			
Medicare #: _____ Veteran #: _____ Other Insurance # _____			
[ ] Same as above		<b>PRESENT LOCATION</b>	
Facility: _____		Street: _____	
City: _____ State: _____ Zip: _____ Phone: _____			
<b>DEMOGRAPHIC DATA</b> (circle appropriate information)			
<b>RACE</b> White Alaska Native American Indian Black Hispanic Asian/Pac.Is. Other _____	<b>SEX</b> Female Male  <b>PRIMARY LANGUAGE</b> _____	<b>MARITAL STATUS</b> Married Widowed Divorced Separated Single	<b>EDUCATION</b> Less than third 3rd through 8th Some High Schl H.S. Graduate Some College College Graduate Other
<b># _____ TOTAL IN HOME</b> _____ Lives Alone _____ Spouse _____ Child(ren) _____ Parent(s) _____ Other Relative(s) _____ Non-Relative(s) _____ Other		<b>LIVING ARRANGEMENT</b> Owns Home Rents Home/Apt Foster Home Residential Facility Pioneers' Home Nursing Facility Other _____	
<b>REASON FOR REFERRAL</b>			
HCB Waiver Program for:		Is this an Adult Protective Services Case? [ ] Yes [ ] No [ ] Unknown	
[ ] Older Alaskans		[ ] Other: _____	
[ ] Adults with Physical Disabilities			
<b>PRESENTING PROBLEMS</b>			
This section may be more than one page in length; it may also be attached as additional pages.			
<b>I. Problem List:</b>			
(The assessor should list the client's present problems in this section. Include the client's Medical diagnoses and Nursing diagnoses, self care deficits, and number of falls here. Include dates of significant illnesses and injuries.)			
<b>II. Current Condition:</b>			
(Type a brief 1 paragraph narrative describing clients current status/condition here)			
<b>III. Nursing Needs:</b>			
(Type list of client's specific needs for nursing care here, which will qualify them for waiver eligibility. Specify whether each need requires <u>assessment</u> , <u>monitoring</u> , or <u>provision</u> of nursing care. Needs identified here serve as the basis for the waiver plan of care.)			
Care Coordinator Signature		Date	
Care Coordination Agency:			

**TREATMENT/THERAPIES/NURSING SERVICES:** Indicate whether client currently receives (R) or needs (N), frequency of service (e.g., if 2 or 3 x/wk, list this under the weekly column), who provides (if provided), and any comments.

SERVICES	Receives or Needs (R or N)	Frequency of Service			PROVIDER	COMMENTS
		daily	weekly	monthly		
Ambulation						
Bandage/Dressing Changes						
Bladder Program/Urinary Incontinence						<input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent
Bowel Program						<input type="checkbox"/> Incontinence <input type="checkbox"/> Constipation
Catheter Care						
Chemotherapy						
Feeding: Tube						
Feeding: Parenteral/IV						
Feeding: Syringe						
Injections						
Medications/Monitoring						
Occupational Therapy						
Oxygen (specify liters/minute)						<input type="checkbox"/> continuous <input type="checkbox"/> as needed
Ostomy Care						
Physical Therapy						
Radiation						
Range of Motion						
Respiratory Therapy						
Skin Care						
Speech Therapy						
Wound Care						
Other: _____						
—						
_____						
—						
_____						
—						

**Additional Nursing or Care Needs:**

**MEDICATIONS:** List all prescription and over the counter drugs being used by the client, the dose, frequency, how they are taken (route), length of time used (duration), who helps the client use the medication, and verification by the physician that the medication is currently prescribed. Use the following codes to record the information. Additional pages may be attached as needed.

Frequency Code:

01 = (QD) daily      04 = (QID) 4 x daily      07 = (QOD) every other day      10 = Other (describe)  
 02 = (BID) 2 x daily      05 = (Q) 5 or more daily      08 = (HS) at bedtime      88 = (NA) Not Applicable  
 03 = (TID) 3 x daily      06 = (PRN) as needed      09 = Weekly      99 = Don't Know/No Response

Route Code:

01 = Oral      03 = Injection      05 = Inhalant      88 = (NA) Not Applicable  
 02 = Topical (skin)      04 = Rectal/Vaginal      06 = Other (describe)      99 = Don't Know/No Response

Who Code:

01 = Self      04 = RN or LPN      06 = Other Agency      88 = (NA) Not Applicable  
 02 = Caregiver      05 = Home Health Aide      07 = Other (describe)      99 = Don't Know/No Response

NAME OF MEDICATION	Dosage	Frequency	Route	Who	Length of Use	Physician Verification	COMMENTS
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

**FACTORS THAT MAY AFFECT INSTITUTIONALIZATION** (check all that apply)

(The more factors checked the more at risk of institutionalization)

☐ Has moderate to total needs for assistance with personal care      Is incontinent of ☐ bowel ☐ bladder      ☐ Needs assistance with multiple prescribed medications not for sale over the counter  
☐ Is 75 years of age or older      ☐ Lives alone      ☐ Is without adequate family or other social support

**Last Physician Visit:**

☐ Within last month  
☐ 1-6 months  
☐ 7 months to 1 year  
☐ Over 1 year

## Reason:

☐ Routine/Annual  
☐ Treatment (Condition: \_\_\_\_\_)  
☐ New Problem: \_\_\_\_\_

**Hospital Admission in Last Year:**

\_\_\_\_\_ # of Admissions      \_\_\_\_\_ # of Days

## Reason:

☐ Illness  
☐ Accident  
☐ Surgery  
☐ Diagnostic/Evaluation  
☐ Treatment/Therapy  
☐ Other \_\_\_\_\_

**Nursing Home Admission in Last Year:**

\_\_\_\_\_ # of Admissions      \_\_\_\_\_ # of Days

## Reason:

☐ Illness  
☐ Recovery/Therapy  
☐ Respite  
☐ Other \_\_\_\_\_

At present client is ☐ low ☐ moderate ☐ high risk for admission to a Nursing Facility .

☐ Diverted from impending NF admission?      ☐ Deinstitutionalized (removed) from NF?      ☐ Other: (provide details below)

Additional information:

\_\_\_\_\_

\_\_\_\_\_



**MEDICAL CERTIFICATION**

for determining NF eligibility for HCB Waiver Programs

(Note: Physician, Advanced Nurse Practitioner or Physician Assistant signing here, please include name/address under physician information section on next page)

Primary

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Secondary

Diagnosis: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge the above information is true, accurate, and complete and the requested services are medically necessary.

Provider

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ ID#: \_\_\_\_\_

\_\_\_\_\_

Printed Provider Name: \_\_\_\_\_

**CARE COORDINATOR** (to be completed by care coordinator completing assessment)

Assessor

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Agency Name: \_\_\_\_\_

\_\_\_\_\_

Supervisor Approval (if required): \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**DIVISION OF SENIOR SERVICES APPROVAL****HCB Waiver Program Level of Care**☐ Approved Nursing Facility Level of care☐ Deferred NF LOC Date: \_\_\_\_\_

Reason: \_\_\_\_\_

☐ Denied NF LOC

Reason: \_\_\_\_\_

Period Approved: (one year from approval date unless specified otherwise) \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

**SECTION II: Comprehensive Assessment for HCB Waiver Plan of Care****PERSONAL CONTACTS****LEGAL REPRESENTATIVE(S):** ☐ Self or:

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home PH \_\_\_\_\_

☐ Parent ☐ Power of Attorney (POA) ☐ Durable POA ☐ Legal Guardian ☐ Conservator Assisted with assessment? ☐ yes ☐ no

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home PH \_\_\_\_\_

☐ Parent ☐ Power of Attorney (POA) ☐ Durable POA ☐ Legal Guardian ☐ Conservator Assisted with assessment? ☐ yes ☐ no**CAREGIVER(S):**

Primary: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home PH \_\_\_\_\_

Assisted with assessment? ☐ yes ☐ no

Secondary: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home PH: \_\_\_\_\_

Assisted with assessment? ☐ yes ☐ no**EMERGENCY CONTACT(S):**

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home

PH: \_\_\_\_\_ Assisted with assessment? ☐ yes ☐ no

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home

PH: \_\_\_\_\_ Assisted with assessment? ☐ yes ☐ no**ADVANCED DIRECTIVES**Does client have living will? ☐ yes ☐ no Durable power of attorney? ☐ yes ☐ no If not, have they been informed? ☐ yes ☐ no**SUMMARY OF CURRENT/PAST COMMUNITY PROVIDERS** (optional section)

NAME:	ADDRESS:	PHONE:	PROVIDER STATUS	CLIENT SATISFACTION
_____	_____	_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

**PHYSICIAN/MEDICAL PROVIDER INFORMATION** (list primary provider first)

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HEALTH CONDITION:** Indicate whether the client, caregiver and/or physician perceive the following conditions as problems or limiting to the client. Complete as possible or necessary for each reporter (client, caregiver, physician). Indicate whether the client is being treated for the conditions listed. Under comments, indicate age of diagnosis for asterisked (\*) conditions.

HEALTH CONDITION	Client		Caregiver		Physician		Treatment		COMMENTS
	no	yes	no	yes	no	yes	no	yes	
<b>HEART/CIRCULATION:</b> Circulatory Problems									
Congestive Heart Failure 428.0									
Heart Attack/Heart Disease									
High Blood Pressure 401.9									
Other: specify _____									
<b>RESPIRATORY:</b> Asthma 493.9									
Bronchitis									
Emphysema 492.8									
Pneumonia 486									
Tuberculosis									
Other: specify _____									
<b>NEUROLOGICAL:</b> Alzheimer's Disease 330									
Autism *									
Cerebral Palsy 343.9 *									
Epilepsy/Seizure Disorder 780.3 *									
Head Injury *									
Mental Retardation *									
Multiple Sclerosis *									
Muscular Dystrophy *									
Spina Bifida *									
Spinal Cord Injury 952.9 *									
Stroke									
Other: specify _____									
<b>SENSORY IMPAIRMENT: *</b> Hearing									
Vision: [ ] glaucoma [ ] cataracts									
Other: specify _____									
<b>OTHER:</b> Arthritis 716.9									
Bladder/Kidney/Urinary Tract Problem									
Cancer 199.1									
Communication/Speech Disorder *									
Dental									

Diabetes 250									
Drug/Alcohol									
Fractures									
HIV/AIDS									
Incontinent: bladder									
Incontinent: bowel									
Intestinal/Stomach/Bowel Problem									
Mental Illness									
Osteoporosis 733									
Pain									
Sexual Problem									
Sleep Problem									
Other: specify _____									
_____									
_____									
Allergies: _____									
GENERAL COMMENTS:									
NUTRITION & DIET: Indicate eating problems/cause and special dietary needs.									
EATING PROBLEM	no	yes	COMMENTS			DIETARY NEEDS	no	yes	COMMENTS
Chewing						Pureed food			
Lack/poor fitting dentures						No added salt			
Difficulty swallowing						Low salt			
Lack of appetite						Diabetic diet			
Food allergies						Low fat/cholesterol			
Lack of money for food						Dietary supplements			
Other: _____						Other: _____			
Current Wt:                      Height:						Meals eaten daily? [ ] 1 or less   [ ] 2   [ ] 3   [ ] more than 3			
Recent Weight Loss? (how much/over time?)									
GENERAL COMMENTS:									

<b>COGNITIVE/BEHAVIORAL:</b> Indicate client's cognitive/behavioral status by completing section below.						
<b>MEMORY:</b> (Ability to recall what was learned/known)  <u>Short Term</u> (ability to recall after 5 minutes): <input type="checkbox"/> memory OK <input type="checkbox"/> memory problem Onset of Difficulty: <input type="checkbox"/> 1-6 months <input type="checkbox"/> 6 mos.-1 year <input type="checkbox"/> over 1 yr. <input type="checkbox"/> Unknown  <u>Long Term</u> (ability to recall past): <input type="checkbox"/> memory OK <input type="checkbox"/> memory problem Onset of Difficulty: <input type="checkbox"/> 1-6 months <input type="checkbox"/> 6 mos.-1 year <input type="checkbox"/> over 1 yr. <input type="checkbox"/> Unknown						COMMENTS:
<b>DAILY DECISION MAKING SKILLS</b> (able to make decisions about day to day activities):  <input type="checkbox"/> Functions independently <input type="checkbox"/> Problems in new situations only <input type="checkbox"/> Requires cues and/or supervision <input type="checkbox"/> Unable to make decisions						COMMENTS:
Rate the following cognitive/behavior patterns according to the following codes by placing a 'X' in the appropriate column: Unable to assess    Not a problem    Occasional Problem (1-2 times monthly)    Frequent Problem (several times weekly)    Daily Problem						
PATTERN	Unable to Assess	Not a Prob.	Occ.	Freq.	Daily	COMMENTS:
<b>ORIENTATION:</b> Recognizes family members/caregivers						
Orientation in home, able to find bedroom/bathroom, etc. without assistance						
Completes routine activities without confusion						
<b>BEHAVIOR:</b> WANDERING (moves with no rational purpose, seemingly oblivious to needs/safety)						
VERBALLY ABUSIVE (threaten, screams, curses at others)						
PHYSICALLY ABUSIVE (hits, shoves, scratches, sexually abusive to others)						
SOCIALLY INAPPROPRIATE/DISRUPTIVE (makes disruptive sounds, self-abusive acts, sexual behavior/disrobing in public, smeared food/feces, etc.)						
<b>MOOD:</b> VERBAL EXPRESSIONS OF DISTRESS (vocal expressions of sadness, sense that nothing matters, hopelessness, worthlessness, anxiety or grief)						
OBSERVABLE SIGNS OF MENTAL DISTRESS Tearfulness, emotional, groaning, sighing, breathlessness						
Motor agitation such as pacing, handwringing or picking						
Failure to eat or take medications, withdrawal from selfcare or leisure activities						
Persistent concern with health						
Recurrent thoughts of death (e.g., believes s/he is about to die)						
Suicidal/homicidal thoughts/actions						
Other (describe:_____)						

**FUNCTIONAL INFORMATION:** Indicate the level at which the client is able to perform the listed activities by circling the level of performance. Indicate the source(s) and frequency of help. Under comments briefly describe how client manages the activity or the help required including the type of assistive devices currently used. Use the following codes to record the information.

Level of Performance Code:

0 = Independent

1 = Assistive device/mechanical assistance only

2 = Supervision and non-physical human assistance (oversight/verbal cues)

3 = Supervision and minimal physical assistance

4 = Substantial human physical assistance

5 = Maximum physical assistance (total dependence)

Source of Help Code:

0 = None

2 = Children

4 = Other relatives

6 = Private paid help

8 = Other

1 = Spouse

3 = Parent(s)

5 = Friend/volunteer

7 = Publicly funded help

Frequency of Help Code:

0 = Not provided

2 = 2-3 times/week

3 = 4-6 times/week

4 = daily

5 = several times per day

1 = once/week or less

ACTIVITIES OF DAILY LIVING	Performance Level	Source(s)	Frequency	COMMENTS
EATING/DRINKING (Get food/liquids into the body)	0 1 2 3 4 5		0 1 2 3 4 5	
TOILETING (Get to/from toilet room, transfer on/off toilet, manage clothes, clean/flush)	0 1 2 3 4 5		0 1 2 3 4 5	
BATHING (Get to/from tub, fill tub/turn on shower, wash/towel dry)	0 1 2 3 4 5		0 1 2 3 4 5	
TRANSFERS (Get in/out of bed/chair/car, etc.)	0 1 2 3 4 5		0 1 2 3 4 5	
DRESSING (Get clothes, put them on, fasten/take off)	0 1 2 3 4 5		0 1 2 3 4 5	
GROOMING (Comb/brush/care for hair, shave, brush teeth/clean dentures)	0 1 2 3 4 5		0 1 2 3 4 5	
<b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING</b>				
MEAL PREPARATION (Plan, prepare, cook, and serve food)	0 1 2 3 4 5		0 1 2 3 4 5	
SHOPPING (Get to/from store, select/pay/get food home/put away)	0 1 2 3 4 5		0 1 2 3 4 5	
MEDICATIONS (Take appropriate dosage at correct times as directed)	0 1 2 3 4 5		0 1 2 3 4 5	
HOUSEKEEPING (Dust, wash dishes, make beds, vacuum/sweep/clean floors)	0 1 2 3 4 5		0 1 2 3 4 5	
LAUNDRY (Put clothes in/out washer/dryer, hand wash/dry, fold/put away)	0 1 2 3 4 5		0 1 2 3 4 5	
COMMUNICATION (Communicate needs/respond to others)	0 1 2 3 4 5		0 1 2 3 4 5	
TASK PLANNING (Plan/carry out routine activities, such as dressing/bathing etc.)	0 1 2 3 4 5		0 1 2 3 4 5	
MONEY MANAGEMENT (Pay bills, write checks, handle cash, make change)	0 1 2 3 4 5		0 1 2 3 4 5	
TELEPHONE (Look up numbers, dial/answer phone)	0 1 2 3 4 5		0 1 2 3 4 5	
TRANSPORTATION (Arrange/use any transportation)	0 1 2 3 4 5		0 1 2 3 4 5	
<b>MOBILITY</b>				
MOBILITY INDOORS (Move around inside home)	0 1 2 3 4 5		0 1 2 3 4 5	
MOBILITY OUTDOORS (Move around outside, within walking distance of home)	0 1 2 3 4 5		0 1 2 3 4 5	
CLIMB STAIRS (Go up/down flight of stairs, negotiate other steps)	0 1 2 3 4 5		0 1 2 3 4 5	

<b>ASSISTIVE DEVICES:</b> Indicate availability and need of all assistive devices by placing an 'X' in the appropriate column (has & uses) or (needs & doesn't have). If has and doesn't use, indicate under comments.							
DEVICE	Has & Uses	Needs & Doesn't Have	COMMENTS:	DEVICE	Has & Uses	Needs & Doesn't Have	COMMENTS:
<b>MOBILITY:</b> Self propelled wheelchair				<b>SKIN CARE:</b> Special mattress pad			
Battery propelled wheelchair				Special mattress			
Ramp				Gel pad/second skin			
Walker/Cane				Body protectors			
Prosthesis				Whirlpool			
Backbrace				<b>COMMUNICATION:</b> Hearing aid			
Crutches				TDD, teletype			
Support dog				Interpreter, sign			
Transfer board				Interpreter, language			
Lift				Lifeline			
<b>EATING:</b> Dentures/partial plate				Voice box			
Hand splint/brace				Symbol board			
Special utensils/plate				Communication board			
Gastronomy tube				Picture book			
<b>TOILETING:</b> Raised toilet seat				<b>MISCELLANEOUS:</b> Oxygen concentrator			
Incontinence pads				Ventilator			
Bed pan/urinal				Pacemaker			
Portable commode				Prosthesis			
Grab bars				Hospital bed			
Catheter				Other specialty lifts			
Ostomy equipment				Other: _____			
<b>BATHING:</b> Bath bench				<b>VISION:</b> Glasses or contacts			
Grab bar/tub rail				Lens			
Hand-held shower				Talking book			
Shower chair				Braille			
				Magnifying lens			
<b>COMMUNICATION:</b> Indicate client's communication abilities by circling appropriate response below.							
<b>VISION:</b> (Ability to see in normal light with glasses/contacts if used) Good - sees regular print in newspapers/books Fair - sees headlines but not regular print in newspapers Poor - cannot headlines Blind - no functional vision COMMENTS:				<b>MAKING SELF UNDERSTOOD:</b> (Ability to express self, however able) Understood Usually Understood - has difficulty finding words/finishing thoughts Sometimes Understood - ability is limited to making concrete requests Never/Rarely Understood COMMENTS:			
<b>HEARING:</b> (Ability to hear with hearing aid if used) Good - hears normal conversation, TV, phone Fair - some problems hearing when not in a quiet setting Poor - hear only if volume is turned up or speaker raises voice Deaf - no functional hearing COMMENTS:				<b>ABILITY TO UNDERSTAND OTHERS:</b> (Ability to understand verbal information - however able) Understands Usually Understands - may miss some part/intent of message Sometimes Understands - responds adequately to simple direct communication Never/Rarely Understands COMMENTS:			

**PHYSICAL ENVIRONMENT:** Does the client's physical environment present obstacles that should/could be changed or eliminated to promote his/her independence and/or functional capacity? Assessor should ask if there are any obstacles/problems and not give examples from the list below. Indicate whether the problem can be remedied by the following code:

NA = Item/condition does not exist

Minor = Minor repair (under \$500 and/or friends/family can fix)

Major = Major repair (over \$500 and/or professional must fix)

CONDITION	Problem		Repair Needed			DESCRIPTION
	no	yes	NA	minor	major	
Safe access to all necessary areas						
Security (locks on windows/doors)						
Adequate bathing facilities						
Adequate toilet facilities						
Adequate running water						
Adequate electricity						
Adequate heating						
Working appliances						
Access to laundry facilities						
Access to telephone						
Condition of stairs						
Adequate sanitation (trash removal, etc.)						
Adequate outdoor maintenance (snow shoveling, etc.)						
Safety of neighborhood						
Adequate pet care						

**VOLUNTARY SUPPORT SYSTEM:** The person the client relies on the most for help in caring for themselves should be listed as the primary caregiver on the first page of assessment as well as the name of the person who also helps them on a regular basis (secondary caregiver). In addition, the source of help (spouse, child, etc.) for day to day activities should be identified in the functional information section. This section is intended to gain further information regarding the client's voluntary support system.

**CLIENT:**

Does your primary caregiver live with you? ☐ yes ☐ no

If yes, what is their condition? ☐ cares for self ☐ requires some care in home ☐ requires total care in home

How is caregiving working? ☐ Very good ☐ Good ☐ Fair ☐ Poor

Who else may be able to help you care for yourself?

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home PH: \_\_\_\_\_

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work PH: \_\_\_\_\_ Home PH: \_\_\_\_\_

**ASSESSOR:**

In your judgment, how well does existing caregiver(s) meet needs of client? ☐ Excellent ☐ Adequate ☐ Inadequate

In your judgment, do you expect caregiver(s) ability to meet the client's need to:?

☐ Increase ☐ Remain the same ☐ Decrease slightly ☐ Decrease substantially

In your judgment, what is overall stress level for existing caregiver(s) in meeting client's needs?

☐ Low ☐ Moderate ☐ High

COMMENTS: \_\_\_\_\_



**SERVICES:** Indicate whether the client currently receives services by formal or informal providers, whether the unmet need for care can be provided by formal or informal (family, friends, other caregivers) providers, or whether the unmet need for care could be met by formal or informal providers, but is not available.

SERVICE	Currently Receives		Unmet Need <u>Can</u> Be Met By:		Unmet Need Could Be Met By, But Is <u>Not</u> Available:		COMMENTS
	formal	informal	formal	informal	formal	informal	
Acute Hospital							
Adult Day Care							
Adult Foster Home							
Adult Residential Care							
Care Coordination							
Chore							
Counseling							
Energy Assistance							
Environmental Modifications							
Errand Service							
Escort to Medical							
Escort to Other							
Financial Budget Assistance							
Friendly Visitor							
Guardianship/Conservatorship							
Habilitation							
Home Health Nurse							
Home Maintenance							
Hospice							
ICF/MR							
Laundry							
Legal services							
Meals							
Medical Care							
Nursing Facility							
Occupational Therapy							
Ombudsman							
Personal Care							
Physical Therapy							
Private Duty Nursing							
Protective Services							
Recreation/Socialization							
Residential/DD							
Respite Services							
Shopping Service							
Specialized Medical Equipment/Supplies							
Speech Therapy							
Telephone Reassurance							
Transportation to Medical							
Transportation to Other							
Weatherization							
Vocational Rehabilitation							

**ASSESSMENT SUMMARY COMMENTS:****[ ] CHOICE for the Elderly Waiver****[ ] CHOICE for Adults with Physical Disabilities Waiver**

The Assessment Summary consists of three paragraphs and focuses on the psycho-social aspects of the client. This section may be more than one page long.

(1<sup>st</sup> paragraph: briefly review client's history)

(2<sup>nd</sup> paragraph: Briefly summarize client's current condition and problems.)

(3<sup>rd</sup> paragraph: State expected benefits for client's participation in the waiver program.)

---

Care Coordinator Signature

Date

**Residential Supported Living Services**  
**Waiver PLAN OF CARE Supplement   [ ] APD   [ ] OA**

**Mandatory: To be completed for all Residential Supported Living clients in addition to their Home & Community Based Plan of Care**

Client Name: \_\_\_\_\_ Wvr Case # \_\_\_\_\_ Care Coordinator \_\_\_\_\_

RSL Provider: \_\_\_\_\_ Other Provider Agency: \_\_\_\_\_ Plan Start Date: \_\_\_\_\_

<b>SPECIFIC RSL PROBLEMS/NEEDS:</b>	<b>SERVICES (What, When, How Often) Specify start and end dates</b>	<b>RSL PROVIDER - specify type and scheduling of care to be provided.</b>	<b>OTHER PROVIDER - specify type and scheduling of care to be provided.</b>	<b>EXPECTED SERVICE OUTCOMES</b>
<b>Nutrition:</b>				
<b>Bathing &amp; Hygiene:</b>				
<b>Toileting/Incontinence:</b>				
<b>Skin Care:</b>				
<b>Dressing:</b>				
<b>Grooming:</b>				
<b>Medication Management, Supervision, and Assistance:</b>				

<b>Laundry/Chores:</b>				
<b>Ambulation/Safety:</b>				
<b>Socialization:</b>				
<b>Other Needs: eg., weights, vital signs, wound care, etc. : (Req'd Completion)</b>				
<b>Other Needs: eg., monitor seizure activity, chest pain, etc.: (Req'd Completion)</b>				
<b>Other Needs Met by Informal Supports Such as family, friends, neighbors: (Req'd Completion)</b>				
<b>Transportation:</b>				
<b>Coordinated care:</b>	The Care Coordinator and Physician are kept informed of changes in client condition.	The RSL provider, caregivers, and family members will provide needed information.	The PCA workers will provide needed information.	Care Coordinators and Physician are able to respond to changes in client condition.

*Please read the following statements. Check the boxes to show that you have read and understood the statements.*

- ☐ I have participated in the planning of my own care and agree with the above plan of care.
- ☐ I understand a copy of my plan of care will be sent to service providers so they will know which services I am to receive.

I understand that I have the right to:

- ☐ change providers, including care coordinators, at any time;
  - ☐ get more information about my plan of care from the Division of Senior Services at 269-3666; 1-800-478-6065;
  - ☐ refuse any portion of the care plan;
  - ☐ be treated with respect and dignity;
  - ☐ self-determination, including participation in developing my own plan of care;
  - ☐ privacy and confidentiality;
  - ☐ be given a fair and comprehensive assessment of my health and functional, psycho-social and cognitive ability;
  - ☐ have access to needed health and social services;
  - ☐ know the cost of service before receiving care;
  - ☐ be notified in writing of any denial, termination, or change in services;
  - ☐ withdraw from the process at any time;
  - ☐ a grievance procedure in the event I feel my rights have been violated or I have been treated improperly;
  - ☐ choose between home and community-based waiver services and institutional care;
- appeal any decision about my eligibility or plan by contacting the Division of Medical Assistance Fair Hearing Representative at 562-3671 or toll free at 1-800-211-7470.

**CLIENT SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**CARE COORDINATOR:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**RSL PROVIDER:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Alaska Nursing Facility Level of Care Scoring Standards  
For Long Term Care and Waivers.**

<b>Category</b>		<b>Minimum Eligibility Threshold is 40 Points.</b>			
<b>1. Skilled Care Needs including but not limited to Home Health Agency or private duty nursing Services in a community setting.</b>	None.	Short-term, intermittent visits for the purposing of monitoring, observation and/or teaching.	One skilled care need provided on an ongoing or regular basis for a stable long-term condition – ostomy care, phlebotomy, tracheostomy care, etc.	One or more skilled care needs for the purpose of maintaining or improving client's current condition – uncontrolled diabetes, recent stroke, wound care requiring sterile dressing changes.	Unstable clients with frequent care needs – ventilator dependant, intravenous therapies, hyperalimentation, gastrostomy, J-tube feedings, active rehabilitation.
	0 Points	5 Points	10 Points	15 Points	20 Points
<b>2. Medication Administration</b>	Independent.	Requires Reminders.	Requires standby assistance and cueing.	Requires physical assistance.	Fully dependent.
	0 Points	5 Points	10 Points	15 Points	20 Points
<b>3. Recent Acute/LTC Admissions</b>	Past 12 months.	Past 9 months.	Past 6 months.	Past 3 months.	Currently in Acute of Long Term Care.
	2 Points.	4 Points	6 Points	8 Points	10 Points
<b>4. Management Intensity of Illness or Disability.</b>	Managed by client accessing outpatient therapies.	In-home services 3 or more days per week.	In-home services 5 or more days per week.	Managed by home health skilled care, personal care, etc. 7 days per week.	Inpatient care.
	2 Points	4 Points	6 Points	8 Points	10 Points
<b>5. Cognitive Impairment Diagnosis.</b>	Functionally independent.	Mild STM loss, occasional confusion.	Moderate STM loss, Questionable judgement, non-compliance.	Advanced short term memory loss, Poor judgement, combativeness.	24-hour supervision related to cognitive impairment or dementia.
	1 Point	2 Points	3 Points	4 Points	5 Points

<b>ADL Scores</b>	<b>Independent</b>	<b>Assistive Device</b>	<b>Oversight &amp; Cueing</b>	<b>Supervision &amp; Minimal assistance</b>	<b>Substantial Assistance</b>	<b>Maximum Assistance</b>
<b>Eating and Drinking</b>	Independent.  0 Points	Requires use of specialized plate, glass, utensils, etc.  1 Point	Requires cues to chew/swallow, locate utensils & food.  2 Points	Requires constant supervision to ensure adequate intake, occasional assistance with feeding by caregiver to complete task correctly/safely.  3 Points	Requires frequent physical assistance by caregivers ensure adequate nutritional intake correctly/safely.  4 Points	Completely dependent on caregivers for performance of eating and drinking tasks.  5 Points
<b>Toileting</b>	Independent.  0 Points	Requires use of Grab bars, raised toilet seat, etc.  1 Point	Requires cues to sit, stand, void, perform Personal hygiene.  2 Points	Requires constant supervision to ensure safe, hygienic toileting, occasional assistance by caregiver with hygiene to complete task correctly/safely.  3 Points	Requires frequent physical assistance by caregivers to toilet hygienically and safely.  4 Points	Completely dependent on caregivers for performance of toileting tasks.  5 Points
<b>Bathing</b>	Independent.  0 Points	Requires use of grab bars, shower chair.  1 Point	Requires cues to sit, stand, wash, rinse, and dry.  2 Points	Requires constant supervision to ensure safe, hygienic bathing and occasional assistance with washing by caregiver to complete task correctly/safely.  3 Points	Requires frequent physical assistance by caregivers to bathe correctly/safely.  4 Points	Completely dependent on caregivers for performance of bathing tasks. 5 Points

<b>Mobility</b> Independent  0 Points	Assistive device, Mechanical assistance only – cane, walker, etc.  1 Point	Supervision and non-physical human assist – verbal cues.  2 Points	Supervision and minimal physical assistance & standby assist – gait belt, aid with balance, guidance.  3 Points	Substantial human physical assistance – one or two person assist required.  4 Points	Maximum physical assistance, total dependence, immobile.  5 Points
<b>Transfers</b> Independent.  0 Points	Requires use of walker, grab bars, etc.  1 Point	Requires cues to sit, stand, ambulate, grasp, and locate objects.  2 Points	Requires constant supervision to ensure safe transfers, and occasional assistance with direction, balance, and foot placement by caregiver to complete task correctly/safely.  3 Points	Requires frequent physical assistance by caregivers to transfer correctly/safely.  4 Points	Completely dependent on caregivers for performance of transfers.  5 Points
<b>Dressing</b> Independent.  0 Points	Requires use of reacher, Velcro closures, etc.  1 Point	Requires cues to select clothing, place limbs in clothing, secure fasteners.  2 Points	Requires constant supervision to ensure appropriate dressing for weather and social events, and occasional assistance with manipulating limbs and clothing by caregiver to complete task correctly/safely.  3 Points	Requires frequent physical assistance by caregivers to dress correctly/safely.  4 Points	Completely dependent on caregivers for performance of dressing tasks.  5 Points
<b>Grooming</b> Independent.  0 Points	Requires use of specialized hairbrush, tooth brush, etc.  1 Point	Needs cues to sit, stand, locate grasp, and manipulate objects - combs, brushes, razors.  2 Points	Requires constant supervision to ensure appropriate grooming and occasional assistance to complete task correctly/safely.  3 Points	Requires frequent physical assistance by caregivers to complete grooming activity correctly/safely.  4 Points	Completely dependent on caregivers for performance of grooming tasks.  5 Points





CONTROL NO. \_\_\_\_\_

**SECTION I - TO BE COMPLETED BY THE RECEIVING FACILITY**

1. TYPE OF REQUEST ____ INITIAL ____ REAUTHORIZATION ____ TRANSFER ____ LEVEL OF CARE CHANGE ____ RETROACTIVE REQUEST	2. RECIPIENT NAME: _____ (LAST) (FIRST) (MI)
3. RECIPIENT ID NO.: _____	4. SEX: _____ M _____ F
5. BIRTHDATE: _____	6. AGE: _____
7. RECIPIENT PRESENTLY AT: _____ HOME _____ ACUTE CARE _____ OTHER (SPECIFY) _____	
REQUESTING PLACEMENT AT: _____	
8. NAME OF FACILITY: _____	9. FACILITY ID#: _____
10. DATE OF ADMISSION: _____ (PLANNED OR ACTUAL)	11. PERIOD OF CARE REQUESTED: _____ TO _____
12. RECOMMENDED LEVEL OF CARE: _____ SNF _____ ICF _____ SWING _____ AW DAYS _____ ICF/MR	
13. FACILITY U.R. COMMITTEE SIGNATURE: _____	DATE: _____

**SECTION II - TO BE COMPLETED BY ATTENDING PHYSICIAN**

14. PRIMARY DIAGNOSIS: _____	15. CODE _____
16. SECONDARY DIAGNOSIS: _____	17. CODE _____
18. MEDICATIONS _____ _____ _____	19. PHYSICIAN RECOMMENDED LEVEL OF CARE: ____ SNF ____ ICF ____ SWING ____ AWD ____ ICF/MR
	20. PERIOD OF CARE REQUESTED ____ TO ____
21. PHYSICIAN NAME: _____	22. ID #: _____
ADDRESS: _____	
TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.	
23. PHYSICIAN SIGNATURE: _____	24. DATE: _____

**SECTION III - TO BE COMPLETED BY DMA (DIVISION OF MEDICAL ASSISTANCE)**

25. DATE RECEIVED IN DMA: _____	26. ACTION TAKEN: _____	____ APPROVED AS REQUESTED
27. APPROVED LEVEL OF CARE: _____ SNF _____ ICF _____ SWING _____ AWD _____ ICF/MR		____ APPROVED AS MODIFIED
28. PERIOD APPROVED FOR: _____ TO _____		____ DEFERRED _____ DATE
29. COMMENTS: _____		____ DENIED
30. SIGNATURE: _____	31. DATE: _____	

NOTE - AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY  
BE SURE THE IDENTIFICATION IS CURRENT BEFORE RENDERING SERVICE.

STATE OF ALASKA  
LONG TERM CARE AUTHORIZATION

32. RECIPIENT'S NAME: \_\_\_\_\_ Phone # \_\_\_\_\_

**SECTION IV - SNF & ICF (COMPLETE PART A ON ALL INITIAL REQUESTS. COMPLETE BOTH PART A & B ON REAUTHORIZATION REQUESTS.)**

PART A

33. CURRENT NURSING NEEDS: (SERVICES RECIPIENT REQUIRES THAT CAN ONLY BE PROVIDED BY LICENSED NURSING PERSONNEL.)

34. REHABILITATION GOALS: \_\_\_\_\_ MAINTENANCE \_\_\_\_\_ ACTIVE REHAB. IF ACTIVE REHAB: STATE GOALS, PROGRESS AND PROJECTED TIME FRAME

35. DISCHARGE PLAN: \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, STATE PLAN WITH TIME FRAME. IF NO, INDICATE WHY NOT.

PART B

36. MAJOR MEDICAL PROBLEMS SINCE LAST REVIEW:

37. NUMBER OF HOSPITALIZATIONS SINCE LAST REVIEW: \_\_\_\_\_ REASONS:

38. NUMBER OF FALLS SINCE LAST REVIEW: \_\_\_\_\_ WERE THERE ANY INJURIES: \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, WHAT WERE THEY?

39. SINCE THE LAST REVIEW, HAVE THERE BEEN ANY UNSUAL OCCURANCES IN RECIPIENT'S LIFE? YES NO  
IF YES PLEASE DESCRIBE: \_\_\_\_\_

40. SIGNATURE OF PERSON COMPLETING THIS SECTION

41. TITLE

42. DATE

State: Alaska

2

Date: July 1, 2001  
Attachment 3 to Appendix D-3 Pages 1-2

## APPENDIX D-4

## a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
  - a. informed of any feasible alternatives under the waiver; and
  - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
  - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
  - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
  - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
  - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

## b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Division of Senior Services Waiver Program Office

**HOME AND COMMUNITY-BASED WAIVER SERVICES  
CLIENT CHOICE OF SERVICES**☐ **CHOICE for Older Alaskans Waiver**☐ **CHOICE for Adults with Physical Disabilities Waiver**

Name	Care Coordinator
Address	Care Coordination Agency
Social Security/Medicaid #	Requested Services Start Date

I understand that: *(please check each box as you read and understand the statement.)*

- ☐ This is an application to find out if I am eligible to have Medicaid pay the cost of my long-term care services.
- ☐ If I am found eligible, and if services are available to me in my community, I may choose to receive care in
1. Licensed nursing home; OR
  2. Receive special Medicaid Waiver and Community services in my home and in my community; OR
  3. Receive Community services only
  4. I may choose to have no new Medicaid or Community services at all.
- ☐ If I choose to receive care in an institutional facility, the care coordinator named above will help me select a facility to meet my needs.
- ☐ If I choose to receive home and community-based services described in the attached Plan of Care, the DSS Long Term Care Unit staff will review my case to see if I meet the Level of Care eligibility requirements and they will evaluate the services requested to be sure they are appropriate and are available in my community.
- ☐ If I choose to have no Medicaid services but do want to have Community services that are available where I live, my Care Coordinator or DSS staff will refer me to the participating agencies.
- ☐ I have the right to consult with whomever I choose before making this decision, including friends, relatives and advocacy organizations, and that I may authorize any of these people to contact the care coordinator or the Division of Senior Services Long Term Care Unit to provide information in helping make this decision.
- ☐ If I choose home and community-based services but am denied, I may still be eligible for care in an institutional facility.

☐ I will receive written notice and an explanation of my appeal rights as presented in 7 AAC 49. If, for any reason, I am:

1. Found to be ineligible for Medicaid, or
2. Found to be ineligible for Medicaid Waivers
3. Denied my choice of services or service providers,
4. Denied my choice between HCB Waiver or Institutional Care

- ☐ I wish to receive the services described in the attached Plan of Care rather than in an institutional facility.
- ☐ I do not wish to receive the services described in the attached Plan of Care, and request care in an institutional facility.
- ☐ I do not wish to receive the Waiver services described in the attached Plan of Care and request services from (non-Waiver) community-based programs rather than care in an institutional facility.
- ☐ I do not wish to receive the services in the attached Plan of Care at this time.

If I change my mind I will contact the care coordinator or DSS to request services.

Client's Signature

Date

OR Legal Representative's Signature (Relationship)

Date

**Division of Senior Services  
Choice Program  
Notices of Action, Appeals and Hearings**

**Introduction**

Alaska's Administrative Code (7 AAC 49) provides applicants for, and recipients of Medicaid waiver services, the right to:

- 1) Notice of adverse actions
- 2) An appeal of such adverse actions
- 3) A fair hearing

Specifically, 7 AAC 49 states that an opportunity for a hearing must be granted to any client whose request for an application is denied, whose claim to Medicaid services is denied or not acted upon with reasonable promptness, or whose benefits the division plans to modify or terminate.

Clients in process under the Choice program, managed by the Division of Senior Services (DSS), may experience lengthy processing time, denied level of care that results in denial of Medicaid waiver services, or have services or providers changed, modified or denied. They may also receive denials of Medicaid benefits from the Division of Public Assistance (DPA).

**Notice of Adverse Action**

DSS and DPA have the responsibility to provide clients with timely written notice of intent to take action denying, suspending, reducing or terminating assistance. Such notices must include the basis (statute, regulation, and policy) for such action and notify the client of his/her right to a hearing. Care coordinators are sent copies of such notices.

**Care Coordinators as Client Advocates**

Care coordinators have a responsibility to serve as client advocates. In the event of a grievance, care coordinators are expected to offer assistance to the client throughout the process and/or to refer the client to appropriate sources of assistance.

**The Formal Hearing Request**

A request for a hearing may be made orally or in writing by the client, or by the client's representative, within 30 days of receiving a notice from DSS or DPA of intended action. The request can be made to any employee of the Division of Senior Services or to the client's eligibility technician or other staff in the Division of Public Assistance.

Requests for hearings are forwarded to the Division of Medical Assistance (DMA) which has the responsibility for conducting fair hearings involving Medicaid issues. No later than 15 days after the receipt of a request, DMA will schedule a hearing and notify the client in writing of the time, date and place of the hearing.

**Client Assistance**

Upon oral or written request from the client, DMA will provide assistance to the client in obtaining representation, preparing his/her case, and gathering witnesses and/or documents to be used in presenting his/her claim. The client may choose to represent him/herself or have a representative such as a care coordinator, guardian, attorney, friend or family member may be the client representative at the fair hearing.

**Fair Hearing**

DMA's hearing officer will preside over the proceeding, listen to statements, review records/documents and render a decision no later than 90 days after the receipt by the division of the request for a hearing. The hearing officer will provide the decision to the client in writing. Information will be included to inform the client of his/her right to appeal the hearing officer's decision to the Director, Division of Medical Assistance.

**DMA Director's Review**

The client must submit his/her appeal of the decision of the DMA hearing officer to the DMA Director within 15 days of receipt of the hearing officer's written decision. Appeal to the DMA Director constitutes the final administrative action available to a client.

The DMA Director must review the record of the hearing, the hearing officer's decision, and applicable laws, regulations, and policies, and render a written decision. This review must be completed no later than 10 days after receiving a client's request for review. The DMA Directors' decision will be sent to the client in writing and will include a statement of the client's right to judicial review.

**APPENDIX E - PLAN OF CARE****APPENDIX E-1****a. PLAN OF CARE DEVELOPMENT**

1. The following individuals are responsible for the preparation of the plans of care:

\_\_\_\_\_ Registered nurse, licensed to practice in the State

\_\_\_\_\_ Licensed practical or vocational nurse, acting within the scope of practice under State law

\_\_\_\_\_ Physician (M.D. or D.O.) licensed to practice in the State

\_\_\_\_\_ Social Worker (qualifications attached to this Appendix)

  X   Case Manager

  X   Other (specify):

DSS staff meeting care coordination standards may elect to perform this service  
7 AAC 43.1040 (f)

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

\_\_\_\_\_ At the Medicaid agency central office

\_\_\_\_\_ At the Medicaid agency county/regional offices

  X   By case managers

  X   By the agency specified in Appendix A

\_\_\_\_\_ By consumers

\_\_\_\_\_ Other (specify):

\_\_\_\_\_



3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

\_\_\_\_\_ Every 3 months

\_\_\_\_\_ Every 6 months

  X   Every 12 months

\_\_\_\_\_ Other (specify):

\_\_\_\_\_

**APPENDIX E-2****a. MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

1. The recipient's plan of care is written by the care coordinator.
2. DSS approves the plan of care by signing the plan of care .

Final approval of waiver applicants is based on the following:

1. the client meets eligibility requirements for HCB Waiver Medicaid;
2. the client meets the level of care requirements;
3. there is space available on the waiver;
3. there are qualified providers with the capacity to meet service levels approved on the consumer's POC and meet health and safety requirements;
4. the level of care determination and the plan of care have been adequate documented and approved.

Final approval of waiver applicants does not occur until all determinations have been completed and are approved by DSS. The Division of Medical Assistance retains the final review and approval authority for all HCB Waiver administrative activities and expenditures.

**b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE**

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

# Home & Community Based Plan of Care

Adults with Physical Disabilities Waiver

Client Name: \_\_\_\_\_ FY: \_\_\_\_\_ From: \_\_\_\_\_ To: 6/30/ \_\_\_\_\_ FY: \_\_\_\_\_ From: 7/01/ \_\_\_\_\_ To: \_\_\_\_\_

Client APD#: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ Amendment #: \_\_\_\_\_ Effective date of Addition/Change: \_\_\_\_\_

SERVICE TYPE & CLIENT'S IDENTIFIED NEEDS:	SERVICE DESCRIPTION:	PROVIDER(S):	EXPECTED OUTCOME or AMENDMENT RATIONALE:
Specify client's identified nursing need(s) for services requested.	<p><u>Calculation Methodology</u>: Describe method used to calculate units of requested services.</p> <p>Specify <u>Effective Date</u> of all Amendments or changes in client status.</p>	<p>List provider(s) name, address, &amp; Phone #.</p> <p><u>Specify Medicaid Provider #</u> <u>Specify Procedure Codes</u>.</p>	Describe anticipated benefits to client from services provided.
<b>CHOICE Waiver Services:</b>			
<p><b>Coordinated care</b> (7001M -7004M) <b>Need:</b> Choice qualified client requiring professional coordination of multiple services and providers to meet client's needs.</p>	Performs Screening, Assessment, Plan of Care, & Reassessment. The Care Coordinator stays informed of changes in client condition.	<p><b>AGENCY:</b></p> <p><b>CMG#:</b></p>	Care Coordinators are able to respond to changes in client condition as rapidly as changes occur.
<p><b>Ongoing Care Coordination</b> (7005M) <b>Need:</b> Client requires continuous monitoring of needs and provision of services.</p>	Care coordinator will contact client x2 per month and PRN, including 1 home visit; will monitor services provided, assist client with problem solving, and advocate for client needs.	<p><b>Care Coordinator:</b></p> <p><b>CM#:</b></p>	Scheduled care is provided; client can maintain current level of independence in a safe manner.
<p><b>Adult Day Care</b> (7341M) <b>Need:</b> Potential for Social Isolation r/t to complex medical problems and debilitated condition</p>		<p><b>Agency:</b></p> <p><b>HC#:</b></p>	

## Home & Community Based Plan of Care

<b>Chore Service (7301M)</b> <b>Need:</b>		<b>Agency:</b>  <b>HC#:</b>	
<b>Residential Supported Living (7331M)</b> <b>Need:</b>	<b>(Include all care &amp; services to be provided. Option: Complete and submit Plan of Care Supplement for Res. Supported Living)</b>	<b>Agency:</b>  <b>RL#:</b>	<b>(See RSL Plan Supplement)</b>
<b>Respite Services <i>Specify</i></b> <b>Hourly (7201M)</b> <b>Daily (7202M)</b> <b>Need:</b>		<b>Agency:</b>  <b>HC#:</b>	
<b>Spec. Private Duty Nursing</b> <b>ICD9#:</b> <b>Need:</b>	<i>(1 unit equals one hour)</i>	<b>Agency:</b> <b>NA#:</b>  <i>(specify RN or LPN)</i>	
<b>Environmental Modifications (7401M)</b> <b>Admin. Fee: (7402M)</b> <b>Need:</b>		<b>Agency/HC#:</b> or <b>Contractor/EM #:</b>  <i>Copy of bid(s) required</i>	

## Home & Community Based Plan of Care

<b>Transportation (7021M)</b> <b>Escort: (7022M)</b> <b>Need:</b>	   <i>(1 one-way trip equals one unit)</i>	<b>Agency:</b>  <b>HC#:</b>	
<b>Meals</b> <i>Specify home or congregate</i> <b>In Home: (7311M)</b> <b>Congregate: (7312M)</b> <b>Need:</b>		<b>Agency:</b>  <b>HC#:</b>	
<b>Waiver Specialized Equipment &amp; Supplies <u>not</u> covered by regular Medicaid</b> <i>Specify Medicaid Procedure Code(s)</i> <b>Need:</b>	   <i>(Nutritional supplements: 1 can equals 1 unit)</i>	<b>Supplier:</b> <b>MS#:</b> <b>Medicaid Procedure Code(s):</b>	
<b>Residential Habilitation - In-Home Supports (7101M)</b> <b>Need:</b>		<b>Provider:</b> <b>HC#:</b>	
<b>Residential Habilitation - Shared Care (7103M)</b> <b>Need:</b>		<b>Provider:</b> <b>HC#:</b>	

## Home & Community Based Plan of Care

<b>Residential Habilitation - Foster Care (7105M)</b> <b>Need:</b>		<b>Provider:</b> <b>HC#:</b>	
<b>Residential Habilitation - Supported Living (7107M)</b> <b>Need:</b>		<b>Provider:</b> <b>HC#:</b>	
<b>Residential Habilitation - Group Home (7111M)</b> <b>Need:</b>		<b>Provider:</b> <b>HC#:</b>	
<b>Supported Employment Habilitation (7115M)</b> <b>Need:</b>		<b>Provider:</b> <b>HC:</b>	
<b>Day Habilitation (7113M)</b> <b>Need:</b>		<b>Provider:</b> <b>HC#:</b>	

## Home & Community Based Plan of Care

<b>Intensive Active Treatment</b> (7117M) <b>Need:</b>		<b>Provider:</b> <b>HC#:</b>	
<b>Other Medicaid Services:</b> <b>(Req'd Completion)</b>			
<b>Personal Care Services:</b> <b>Need:</b>		<b>Agency:</b>	
<b>Medications:</b> <b>Need:.</b>		<b>Pharmacy:</b>	
<b>Professional Medical Care:</b> <b>Need:</b> Professional Assessment of Condition and ongoing medical supervision of treatment.	.	<b>Provider(s):</b>	Client receives professional medical care in a safe & appropriate manner.

## Home & Community Based Plan of Care

<b>Non-waiver Specialized Equipment and Supplies:</b> <i>Specify Medicaid Procedure Code(s)</i> <b>Need:</b>		<b>Providers:</b>  <b>Medicaid Procedure Code(s):</b>	
<b>Informal Supports: Provided by family, friends, neighbors, etc. (Req'd completion)</b>			
<b>Other Need Met by Informal Supports:</b>			
<b>Other Need Met by Informal Supports:</b>			
<b>Client Safety:</b> Need: Client at risk for injury r/t to hazards of immobility, blindness, and physical debilitation.	All provider staff & family members continually assess client and environment for safety hazards and correct them as necessary.	All Providers & family	Client remains without injury related to transfer, bathing, home hazards, skin care, immobility, or other risk factors.



## Home & Community Based Plan of Care

*Please read the following statements. Check the boxes to show that you have read and understood the statements.*

- ☐ I have participated in the planning of my own care and agree with the above plan of care.
- ☐ I agree to the release of a copy of my plan of care to participating plan providers and agencies directly involved in administering the Medicaid program.

I understand that I have the right to:

- ☐ change providers, including care coordinators, at any time;
- ☐ get more information about my plan of care from the Division of Senior Services at 269-3666; 1-800-478-6065;
- ☐ refuse any portion of the care plan;
- ☐ be treated with respect and dignity;
- ☐ self-determination, including participation in developing my own plan of care;
- ☐ privacy and confidentiality;
- ☐ be given a fair and comprehensive assessment of my health and functional, psycho-social and cognitive ability;
- ☐ have access to needed health and social services;
- ☐ know the cost of service before receiving care;
- ☐ be notified in writing of any denial, termination, or change in services;
- ☐ withdraw from the process at any time;
- ☐ a grievance procedure in the event I feel my rights have been violated or I have been treated improperly;
- ☐ choose between home and community-based waiver services and institutional care;
- ☐ appeal any decision about my eligibility or plan by contacting the Division of Medical Assistance Fair Hearing Representative at 562-3671 or toll free at 1-800-211-7470.

**CLIENT SIGNATURE:** \_\_\_\_\_ **WITNESS:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE CARE COORDINATOR:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE CARE PROVIDER:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Plan of Care is Approved with changes noted and initialed above.**

**Signature of Division of Senior Services Staff Member:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*The start-of-services date cannot precede the level-of-care approval date.*

*The Client Choice of Services form is required with the initial Plan.*

## APPENDIX F - AUDIT TRAIL

## a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):

  X   Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

       Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

       Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

       Other (Describe in detail):

## b. BILLING PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
  - a. When the individual was eligible for Medicaid waiver payment on the date of service;
  - b. When the service was included in the approved plan of care;
  - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

  X   Yes

       No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

  X   All claims are processed through an approved MMIS.

       MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

       The Medicaid agency will make payments directly to providers of waiver services.

  X   The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

       The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

       Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

\_\_\_\_\_  
Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:  
\_\_\_\_\_

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

## APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1  
 COMPOSITE OVERVIEW  
 COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: Nursing Facility

YEAR	PEOPLE	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
YR1	791	\$ 14,784	\$ 11,657	\$ 61,280	\$ 18,085
YR2	931	\$ 14,941	\$ 11,913	\$ 62,628	\$ 18,483
YR3	1,072	\$ 15,103	\$ 12,176	\$ 64,006	\$ 18,889
YR4	1,212	\$ 15,279	\$ 12,443	\$ 65,414	\$ 19,305
FY5	1,365	\$ 15,450	\$ 12,717	\$ 66,853	\$ 19,730

## FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	791
2	931
3	1,072
4	1,212
5	1,365

## EXPLANATION OF FACTOR C:

Check one:

☒ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

☐ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2  
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: Nursing Facility

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following pages.

## APPENDIX G-3

## METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care\*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Residential habilitation, day habilitation, intensive active treatment/therapies, care coordination, meals, supported employment and chore services may be given at assisted living homes or residential supported living facilities. The assisted living homes or RSLA providers document billing recipient, family or other source for the cost of basic board and room which is not reimbursable by Medicaid.

When developing payment rates for above services, room and board components are excluded. Client room and board costs are specifically noted on cost sheet, and are the responsibility of the qualified provider to collect.

Meals reimbursed through the HCB Waivers shall not constitute a full day's regimen and will be limited to 1 or 2 meals per day.

\*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):  
Residential habilitation, day habilitation, intensive active treatment/therapies, care coordination, meals.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

When developing payment rates for above services, room and board components are excluded. Client room and board costs are specifically noted on cost sheet, and are the responsibility of the qualified provider to collect.

Meals reimbursed through the HCB Waivers shall not constitute a full day's regimen and will be limited to 1 or 2 meals per day.

## APPENDIX G-4

## METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

  X   The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

       The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.



## APPENDIX G-5

## FACTOR D'

LOC: Nursing Facility

NOTICE: On July 25, 1994, HCFA published regulations that changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

## APPENDIX G-5

## FACTOR D' (cont.)

LOC: Nursing Facility

Factor D' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).☐ Based on HCFA Form 372 for years \_\_\_\_ of waiver # \_\_\_\_, which serves a similar target population.☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.☒ Other (specify):

Factor D' is based on data from HCFA Form 372 reports, MMIS statistically valid data from FY98-FY01, as well as an allowance for expected growth in service delivery and a 2.2% inflation factor based on the the Anchorage Medical Consumer Price Index (MCPI).

## APPENDIX G-6

## FACTOR G

LOC: Nursing Facility

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

\_\_\_\_\_ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached).  
Attached is an explanation of any adjustments made to these numbers.

  X   Based on trends shown by HCFA Form 372 for prior years of waiver #0262,  
which reflect costs for an institutionalized population at this LOC. Attached is an  
explanation of any adjustments made to these numbers.

\_\_\_\_\_ Based on actual case histories of individuals institutionalized with this disease or  
condition at this LOC. Documentation attached.

\_\_\_\_\_ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this  
request, plus outlier days. Descriptions, computations, and an explanation of any  
adjustments are attached to this Appendix.

\_\_\_\_\_ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D.  
Do not duplicate these costs in your calculation of Factor G.

## APPENDIX G-7

### FACTOR G'

LOC: Nursing Facility

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

## APPENDIX G-7

## FACTOR G'

LOC: Nursing Facility

Factor G' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).☐ Based on HCFA Form 372 for prior years of waiver # 0262.90, which serves a similar target population.☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.☒ Other (specify):  
Factor G' is based on data from HCFA Form 372 reports, MMIS statistically valid data from FY98-FY01, as well as an allowance for expected growth in service delivery and a 2.2% inflation factor based on the the Anchorage Medical Consumer Price Index (MCPI).

## APPENDIX G-8

## DEMONSTRATION OF COST NEUTRALITY

LOC: Nursing Facility

## Year 1

Factor D	\$ 14,784	Factor G	\$ 61,280
Factor D'	\$ 11,657	Factor G'	\$ 18,085
Total D value	\$ 26,441	<Total G value	\$ 79,365

## Year 2

Factor D	\$ 14,941	Factor G	\$ 62,628
Factor D'	\$ 11,913	Factor G'	\$ 18,483
Total D value	\$ 26,854	<Total G value	\$ 81,111

## Year 3

Factor D	\$ 15,103	Factor G	\$ 64,006
Factor D'	\$ 12,176	Factor G'	\$ 18,889
Total D value	\$ 27,279	<Total G value	\$ 82,895

## Year 4

Factor D	\$ 15,279	Factor G	\$ 65,414
Factor D'	\$ 12,443	Factor G'	\$ 19,305
Total D value	\$ 27,722	<Total G value	\$ 84,719

## Year 5

Factor D	\$ 15,450	Factor G	\$ 66,853
Factor D'	\$ 12,717	Factor G'	\$ 19,730
Total D value	\$ 28,167	<Total G value	\$ 86,583